FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0049585

Facility Name: Heartland of Macomb

Address: 8 Doctor Lane (Number) Macomb (City) 61455 (Zip Code)

County: McDonough

Telephone Number: 309-833-5555 **Fax #** 309-833-3749

HFS ID Number:

Date of Initial License for Current Owners: 1966

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Jeff Lewandowski **Telephone Number:** (419) 252-5736
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/15 to 12/31/15 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name) Martin D. Allen
(Title) Director

Paid Preparer
(Signed)
(Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Heartland of Macomb # 0049585 Report Period Beginning: 01/01/15 Ending: 12/31/15

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	80	Skilled (SNF)	80	29,200	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	80	TOTALS	80	29,200	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	11,367	5,109	7,222	23,698	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,367	5,109	7,222	23,698	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.16%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/1989

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/07/11 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 80 and days of care provided 4,529

Medicare Intermediary CGS Administrators, LLC

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Heartland of Macomb # 0049585 Report Period Beginning: 01/01/15 Ending: 12/31/15

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	224,045	16,783	22,518	263,346		263,346		263,346			1
2	Food Purchase		179,499		179,499		179,499	(18,016)	161,483			2
3	Housekeeping	114,589	14,886	809	130,284		130,284		130,284			3
4	Laundry	17,582	17,940	157	35,679		35,679		35,679			4
5	Heat and Other Utilities			98,562	98,562	1,244	99,806		99,806			5
6	Maintenance	42,039	20,244	70,640	132,923		132,923		132,923			6
7	Other (specify):* Med Waste			572	572		572		572			7
8	**TOTAL General Services**	398,255	249,352	193,258	840,865	1,244	842,109	(18,016)	824,093			8
	B. Health Care and Programs											
9	Medical Director			3,318	3,318		3,318		3,318			9
10	Nursing and Medical Records	1,407,627	110,457	24,785	1,542,869	4,174	1,547,043		1,547,043			10
10a	Therapy	599,304	10,703	70,197	680,204		680,204		680,204			10a
11	Activities	54,095	2,557	1,294	57,946		57,946		57,946			11
12	Social Services	81,390		3,026	84,416		84,416		84,416			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,142,416	123,717	102,620	2,368,753	4,174	2,372,927		2,372,927			16
	C. General Administration											
17	Administrative	103,794		253,109	356,903	(115,580)	241,323		241,323			17
18	Directors Fees											18
19	Professional Services			24,429	24,429		24,429	(24,429)				19
20	Dues, Fees, Subscriptions & Promotions			88,972	88,972		88,972	(61,973)	26,999			20
21	Clerical & General Office Expenses	200,235	34,905	323,361	558,501		558,501	(241,086)	317,415			21
22	Employee Benefits & Payroll Taxes			487,354	487,354	18,711	506,065		506,065			22
23	Inservice Training & Education			1,969	1,969		1,969		1,969			23
24	Travel and Seminar			13,822	13,822		13,822		13,822			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			94,441	94,441		94,441		94,441			26
27	Other (specify):*											27
28	**TOTAL General Administration**	304,029	34,905	1,287,457	1,626,391	(96,869)	1,529,522	(327,488)	1,202,034			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,844,700	407,974	1,583,335	4,836,009	(91,451)	4,744,558	(345,504)	4,399,054			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Heartland of Macomb #0049585 Report Period Beginning: 01/01/15 Ending: 12/31/15

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			175,691	175,691	6,370	182,061		182,061			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			609,586	609,586	85,081	694,667	(614,015)	80,652			32
33	Real Estate Taxes			60,247	60,247		60,247		60,247			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			54,784	54,784		54,784		54,784			35
36	Other (specify):*											36
37	**TOTAL Ownership**			900,308	900,308	91,451	991,759	(614,015)	377,744			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		156,485		156,485		156,485		156,485			39
40	Barber and Beauty Shops			7,292	7,292		7,292		7,292			40
41	Coffee and Gift Shops	22,294			22,294		22,294		22,294			41
42	Provider Participation Fee			160,448	160,448		160,448		160,448			42
43	Other (specify):* **IV | X-ray & lab**		1,284	64,074	65,358		65,358		65,358			43
44	**TOTAL Special Cost Centers**	22,294	157,769	231,814	411,877		411,877		411,877			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,866,994	565,743	2,715,457	6,148,194		6,148,194	(959,519)	5,188,675			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Heartland of Macomb # 0049585 Report Period Beginning: 01/01/15 Ending: 12/31/15

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$	10	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(18,016)	2		4
5	Telephone, TV & Radio in Resident Rooms		21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds	(436)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(192)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		27		16
17	Non-Care Related Fees				17
18	Fines and Penalties		21		18
19	Entertainment				19
20	Contributions	(1,127)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(23,153)	19		22
23	Malpractice Insurance for Individuals		25		23
24	Bad Debt	(238,727)	21		24
25	Fund Raising, Advertising and Promotional	(61,973)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Page 5a	(615,895)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (959,519)		$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (959,519)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

Heartland of Macomb

ID# 0049585

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Activity Income	$	11	1
2	Misc. Income		21	2
3	Vending Income	(604)	21	3
4	Accouning/Collection Fees	(1,276)	19	4
5	Collection Agency		19	5
6	Loss on Disposal of Fixed Asset		36	6
7	HCP Lease Interest	(614,015)	32	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(615,895)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland of Macomb # 0049585 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(18,016)	0	0	0	0	0	0	0	0	0	0	(18,016)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(18,016)	0	0	0	0	0	0	0	0	0	0	(18,016)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(24,429)	0	0	0	0	0	0	0	0	0	0	(24,429)	19
20	Fees, Subscriptions & Promotions	(61,973)	0	0	0	0	0	0	0	0	0	0	(61,973)	20
21	Clerical & General Office Expenses	(241,086)	0	0	0	0	0	0	0	0	0	0	(241,086)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(327,488)	0	0	0	0	0	0	0	0	0	0	(327,488)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(345,504)	0	0	0	0	0	0	0	0	0	0	(345,504)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heartland of Macomb # 0049585 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(614,015)	0	0	0	0	0	0	0	0	0	0	(614,015)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(614,015)	0	0	0	0	0	0	0	0	0	0	(614,015)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(959,519)	0	0	0	0	0	0	0	0	0	0	(959,519)	45

Facility Name & ID Number Heartland of Macomb # 0049585 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
HCR Manor Care, LLC	100			HCR Manor Care Svc	Toledo	Home Office
				HL Empl Svcs, LLC	Toledo	Personnel
				HL Rehab Svcs, LLC	Toledo	Therapy Mgmt Svcs
				HL Rehab Svcs, LLC	Toledo	Therapy Services
				HL Home Health Care	Toledo	Nursing Staff

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	$ 253,109	HCR Manor Care Services, LLC	100.00%	$ 253,109	$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	2,866,994	Heartland Employment Services, LLC	100.00%	2,866,994		4
5	V	10a	Therapy Management	8,759	Heartland Rehabilitation Services, LLC	100.00%	8,759		5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 3,128,862			$ 3,128,862	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Heartland of Macomb # 0049585 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Heartland of Canton IL, LLC	Canton				1
2			Heartland of Decatur IL, LLC	Decatur				2
3			Heartland of Galesburg IL, LLC	Galesburg				3
4			Heartland of Henry IL, LLC	Henry				4
5								5
6			Heartland of Moline IL, LLC	Moline				6
7			Heartland of Normal IL, LLC	Normal				7
8			Heartland of Paxton IL, LLC	Paxton				8
9			Heartland of Peoria IL, LLC	Peoria				9
10			Heartland-Riverview of East Peoria IL, LLC	East Peoria				10
11			Manor Care at Arlington Heights	Arlington Heights				11
12			Manor Care of Elgin IL, LLC	Elgin				12
13			Manor Care of Elk Grove Village IL, LLC	Elk Grove Village				13
14								14
15			Manor Care of Hinsdale IL, LLC	Hinsdale				15
16			Manor Care of Homewood IL, LLC	Homewood				16
17			Manor Care of Kankakee IL, LLC	Kankakee				17
18			Manor Care of Libertyville IL, LLC	Libertyville				18
19			Manor Care of Naperville IL, LLC	Naperville				19
20			Manor Care of Northbrook IL, LLC	Northbrook				20
21			Manor Care of Oak Lawn (East) IL, LLC	Oak Lawn				21
22			Manor Care of Oak Lawn (West) IL, LLC	Oak Lawn				22
23			Manor Care of Palos Heights (West) IL, LLC	Palos Heights				23
24			Manor Care of Palos Heights (East) IL, LLC	Palos Heights				24
25			Manor Care of Rolling Meadows IL, LLC	Rolling Meadows				25
26			Manor Care of South Holland IL, LLC	South Holland				26
27			Manor Care of Westmont IL, LLC	Westmont				27
28			Manor Care of Wilmette IL, LLC	Wilmette				28
29			Arden Courts of Elk Grove Village IL, LLC	Elk Grove Village				29
30			Arden Courts of Geneva IL, LLC	Geneva				30

Facility Name & ID Number Heartland of Macomb # 0049585 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Arden Courts of Glen Ellyn IL, LLC	Glen Ellyn				1
2			Arden Courts of Hazel Crest IL, LLC	Hazel Crest				2
3			Arden Courts of Northbrook IL, LLC	Northbrook				3
4			Arden Courts of Palos Heights IL, LLC	Palos Heights				4
5			Arden Courts of South Holland IL, LLC	South Holland				5
6			Heartland of Champaign IL, LLC	Champaign				6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Heartland of Macomb # 0049585 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Heartland of Macomb # 0049585 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HCR Manor Care Services LLC
Street Address: 333 North Summitt Street
City / State / Zip Code: Toledo, OH 43604-2617
Phone Number: (419) 252-5500
Fax Number: (419) 254-5495

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities - Pooled	Accumulated Cost	3,924,650,842	559 NFs, HHs,	$ 818,127	$	5,965,685	$ 1,244	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	3,461,495,908	357 NFs	0		5,965,685	0	2
3	5	Utilities - Direct to Western Div S	Accumulated Cost	928,114,340	85 NFs	0		5,965,685	0	3
4	10	Nursing - Pooled	Accumulated Cost	3,924,650,842	559 NFs, HHs, & R	314,713	212,796	5,965,685	478	4
5	10	Nursing - Direct to all SNFs	Accumulated Cost	3,461,495,908	357 NFs	2,144,378	1,338,476	5,965,685	3,696	5
6	10	Nursing - Direct to Western Div S	Accumulated Cost	928,114,340	85 NFs	0	0	5,965,685	0	6
7	17	General & Administrative - Poole	Accumulated Cost	3,924,650,842	559 NFs, HHs, & R	60,268,030	28,103,285	5,965,685	91,611	7
8	17	General & Administrative - Direc	Accumulated Cost	3,461,495,908	357 NFs	14,494,897	5,630,812	5,965,685	24,981	8
9	17	General & Administrative - Direc	Accumulated Cost	928,114,340	85 NFs	3,257,281		5,965,685	20,937	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,924,650,842	559 NFs, HHs, & R	5,205,729		5,965,685	7,913	10
11	22	Employee Benefits - Direct to All S	Accumulated Cost	3,461,495,908	357 NFs	6,264,775		5,965,685	10,798	11
12	22	Employee Benefits - Direct to Wes	Accumulated Cost	928,114,340	85 NFs	0		5,965,685	0	12
13	30	Depreciation - Pooled	Accumulated Cost	3,924,650,842	559 NFs, HHs, & R	3,394,861		5,965,685	5,160	13
14	30	Depreciation - Direct to All SNFs	Accumulated Cost	3,461,495,908	357 NFs	702,366		5,965,685	1,210	14
15	30	Depreciation - Direct to Western I	Accumulated Cost	928,114,340	85 NFs	0		5,965,685	0	15
16										16
17										17
18										18
19	32	Pooled Interest	Accumulated Cost	3,924,650,842		28,376,750		5,965,685	43,134	19
20	32	Directly Assigned Interest	Not Allocated			18,868,647			41,947	20
21										21
22		H/O costs Allocated to non-SNF & Other Divisions				33,166,797				22
23										23
24										24
25	TOTALS					$ 177,277,351	$ 35,285,369		$ 253,109	25

Facility Name & ID Number Heartland of Macomb # 0049585 Report Period Beginning: 01/01/15 Ending: 12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Conv. Sub Debentures		X				$ 581,402	$ 555,518		0.0755	$ 41,947	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7	Pooled Interest										43,134	7
8	Interest Expense / Interest Income										(4,429)	8
9	TOTAL Facility Related						$ 581,402	$ 555,518			$ 80,652	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 581,402	$ 555,518			$ 80,652	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Heartland of Macomb # 0049585 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 60,159	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 60,203	2
3. Under or (over) accrual (line 2 minus line 1).		$ 44	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 60,203	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 60,247	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	57,095	8
	2011	57,405	9
	2012	59,343	10
	2013	60,159	11
	2014	60,203	12

Line 2: = $30,101.52 for 1st half 2014 + $30,101.52 for 2nd half 2014.

Line 4: Used same amount as on line 2.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heartland of Macomb COUNTY McDonough

FACILITY IDPH LICENSE NUMBER 0049585

CONTACT PERSON REGARDING THIS REPORT Jeff Lewandowski

TELEPHONE (419) 252-5736 FAX #: (419) 254-5495

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2014 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-300-953-00	See Attached	$ 58,973.42	$ 58,973.42
2.	11-300-961-00	See Attached	$ 1,229.62	$ 1,229.62
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 60,203.04	$ 60,203.04

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES ___X___ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Heartland of Macomb # 0049585 Report Period Beginning: 01/01/15 Ending: 12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,692 B. General Construction Type: Exterior Masonry Frame Steel, Fire Resistant Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1983	$ 57,104	1
2	Facility		2003	49,141	2
3	TOTALS			$ 106,245	3

Facility Name & ID Number Heartland of Macomb # 0049585 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	58			1983	$ 824,586	$ 28,317		$ 28,317	$	$ 1,179,667	4
5	6			2001	404,817						5
6	Audit adj 7/1/03(#1)			2001	(55,875)						6
7	16			2003	726,962						7
8	Audit adj 7/1/06 (#17)			2003	56,765						8
	Improvement Type**										
9	Current Year Depreciation					104,677		104,677		1,902,424	9
10	Building Improvements (Current Year Depreciation)			1983	19,035						10
11	Land Improvements			1983	300						11
12	Land Improvements - Audit Adj 7/1/03 (#7) - Chg Yr			1984	15,076						12
13	Building Improvements			1985	20,813						13
14	Building Improvements			1986	42,783						14
15	Building Improvements			1986	3,741						15
16	Land Improvements			1986	(60,000)						16
17	Adjust HGCC Purchase			1986	60,000						17
18	Audit Adj 7/1/03 (#2) - Pg 12, Line 16			1987	70,097						18
19	Building Improvements			1987	490						19
20	Interior Renovation			1987	(490)						20
21	Audit Adj 7/1/03 (#8) - Pg 12, Line19			1988	2,068						21
22	Building Improvements			1988	732						22
23	Water Heater			1988	(732)						23
24	Audit Adj 7/1/03 (#3) - Pg 12 Line 22			1988	1,336						24
25	Repair Valve			1988	(1,336)						25
26	Audit Adj 7/1/03 (#4) - Pg 12 Line 24			1988	3,770						26
27	Light Fix-Over Bed			1988	(3,770)						27
28	Audit Adj 7/1/03 (#5) - Pg 12 Line 26			1989	1,614						28
29	Land Improvements			1989	25,315						29
30	Building Improvements			1990	4,980						30
31	Storage Shed			1990	(4,980)						31
32	Audit Adj 7/1/03 (#6) - Pg 12 Line 30			1990	950						32
33	Land Improvements			1990	11,382						33
34	Building Improvements			1990	3,186						34
35	Building (Bldg)			1990	(3,186)						35
36	Audit Adj 7/1/03 (#9) - Pg 12, Line34										36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Heartland of Macomb # 0049585 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Building Improvements	1991	$ 5,547	$		$	$	$	37
38	Building Improvements	1992	10,800						38
39	Land Improvements	1993	23,517						39
40	Building Improvements	1993	13,585						40
41	Building Improvements	1994	51,433						41
42	Land Improvements	1995	4,302						42
43	Building Improvements	1995	121,882						43
44	SMOKE DAMPER	1996	853						44
45	WALLCOVERING	1996	358						45
46	TILE	1996	5,333						46
47	PLUMBING FOR BEAUTY SHOP	1996	3,735						47
48	CABINETS IN PERSONAL CARE	1996	2,450						48
49	ELECTRICAL WIRING FOR PERSONAL	1996	1,740						49
50	TILE FLOOR	1996	824						50
51	ADDITIONAL COST TILE FLOOR	1996	189						51
52	PAINT	1996	1,025						52
53	ADDITIONAL COST A/C (DUCTWORK)	1996	262						53
54	CARPET	1996	846						54
55	COUNTERTOP	1996	894						55
56	PAINTING	1996	1,172						56
57	ADDITIONAL COST FOR SHOWER RENOVATION	1996	278						57
58	HVAC	1996	600						58
59	WALLCOVERING	1996	2,112						59
60	FLOORING	1996	514						60
61	ADDITIONAL WALLCOVERING	1996	6						61
62	WALLCOVERING	1996	382						62
63	CONCRETE	1996	8,812						63
64	PAVING	1996	7,710						64
65	PAVING	1996	13,835						65
66	RENOVATION CHARGES (DUMPSTER)	1996	210						66
67	PAVING-AUDIT ADJ 7/1/03 (#10) - CHG YR	1996	2,652						67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,458,287	$ 132,994		$ 132,994	$	$ 3,082,091	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Heartland of Macomb # 0049585 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,458,287	$ 132,994		$ 132,994	$	$ 3,082,091	1
2	ANGLE BRACKETS FOR HANDRAIL	1997	700						2
3	WALLCOVERING	1997	599						3
4	HANDRAIL	1997	10,069						4
5	PAINTING & WALLCOVERING	1997	15,003						5
6	PAINTING	1997	2,500						6
7	ADDITIONAL COST FOR HANDRAIL	1997	1,480						7
8	COVE BASE	1997	671						8
9	WALL PROTECTION	1997	2,192						9
10	PAINTING & WALLCOVERING	1997	18,964						10
11	(2) NURSES STATION SYSTEMS	1997	11,176						11
12	WALLCOVERING	1997	24						12
13	ELECTRICAL WIRING. OUTLETS & T	1997	3,420						13
14	PAINTING, WALLCOVERING & COVE	1997	19,206						14
15	ADDLT COST FOR A/C	1997	105						15
16	NURSES STATION SYSTEM	1997	4,625						16
17	RENOVATE SHOWER ROOM	1997	939						17
18	A/C HEAT	1997	15,762						18
19	ROOF	1997	3,444						19
20	RENOVATE CENTRAL BATH	1997	2,475						20
21	PLUMBING IN KITCHEN	1997	1,102						21
22	ADDL'T COST FOR A/C	1997	105						22
23	VINLY WALL COVERING FROM INVENTORY	1997	2,425						23
24	HVAC	1997	682						24
25	ADDL'T COST FOR GENERATOR	1997	2,233						25
26	NURSES STATION SYSTEM	1997	1,600						26
27	CABINETS FOR BKKPG & MED RECOR	1997	5,432						27
28	HVAC (ADDL'T COST)	1997	880						28
29	ADDL'T RENOVATION COST	1997	28						29
30	REMODEL BOOKKEEPING OFFICE	1997	150						30
31	ADDL'T GENERATOR COST	1997	120						31
32	CARPET	1997	737						32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,587,135	$ 132,994		$ 132,994	$	$ 3,082,091	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Heartland of Macomb # 0049585 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,587,135	$ 132,994		$ 132,994	$	$ 3,082,091	1
2	DRYWALL	1997	2,750						2
3	PERIMETER ALARM SYSTEM	1997	5,972						3
4	WALLCOVERING	1997	651						4
5	SIDEWALKS	1997	5,875						5
6	Ceiling Tile For Nurses Station	1998	1,446						6
7	Additional Cost for Tile Floor	1998	291						7
8	Wallcovering	1998	414						8
9	Misc Labor & Materials for Gutters	1998	215						9
10	Excavation of Ditch & Storm Sewers	1998	975						10
11	ADDL'T COST FOR PERIMETER ALARM	1998	4,620						11
12	ELECTRICAL WIRING	1998	665						12
13	ADDL'T COST ON FLOORING	1998	16						13
14	ADDL'T COST FOR COUNTERTOPS	1998	604						14
15	TILE FLOOR	1998	704						15
16	CUMMINS/ONAN GENERATOR	1998	24,882						16
17	ADDL'T COST FOR FIRE ALARM SYSTEM	1998	320						17
18	FIRE ALARM CONTROL PANEL	1998	7,925						18
19	A/C HEAT ROOF	1998	672						19
20	GENERATOR	1998	303						20
21	FIRE ALARM SYSTEM	1998	17,066						21
22	GENERATOR	1998	25,364						22
23	HVAC RENOVATION	1998	646						23
24	Audit Adj 7/1/03 (#11) - Pg 12C, Line 23	1998	(646)						24
25	HVAC	1998	283,462						25
26	Audit Adj 7/1/03 (#12) - Pg 12C, Line 25	1998	(5,103)						26
27	SIMPLEX FIRE ALARM SYSTEM	1998	16,846						27
28	ADDL'T COST FOR FIRE ALARM SYSTEM	1998	4,645						28
29	PAINTING & WALLCOVERING	1999	3,457						29
30	DUCTWORK	1999	467						30
31	RE-KEY FACILITY	1999	779						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,993,418	$ 132,994		$ 132,994	$	$ 3,082,091	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Heartland of Macomb # 0049585 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,993,418	$ 132,994		$ 132,994	$	$ 3,082,091	1
2	OVERHEAD FROM CONSTRUCTION	1999	4,880						2
3	AUDIT ADJ 7/1/03 (#13) - PG12D, LINE 2	1999	(4,880)						3
4	OVERHEAD FROM CONSTRUCTION	1999	27,042						4
5	AUDIT ADJ 7/1/03 (#13) - PG12D, LINE 4	1999	(27,042)						5
6	PAINTING	1999	1,245						6
7	EXIT FIXTURES	1999	2,074						7
8	ARMSTRONG FLOORING	1999	443						8
9	SPRINKLER UPGRADE	1999	14,500						9
10	LOCKING DOOR HARDWARE	1999	2,516						10
11	SPRINKLER UPGRADE	1999	14,500						11
12	DOOR LOCKS	1999	1,434						12
13	PLUMBING IN RESTROOMS	1999	1,330						13
14	SPRINKLER UPGRADE	1999	26,084						14
15	EXIT LIGHT	1999	2,074						15
16	FLOW SWITCH FOR SPRINKLER SYST	1999	342						16
17	QUARRY TILE	1999	9,916						17
18	SPRINKLER UPGRADE	1999	5,798						18
19	AUDIT ADJ 7/1/03 (#14) - PG12D, LINE 18	1999	(2,900)						19
20	SMOKE DOORS	1999	1,184						20
21	HVAC	1999	1,557						21
22	VOLUME DAMPERS FOR AIR SUPPLY DUCT	1999	2,445						22
23	DOORS AND DOOR OPENERS	1999	3,500						23
24	DOORS AND FRAMES	1999	11,283						24
25	COMPRESSOR FOR AIR CONDITIONING	1999	3,705						25
26	SECURE CARE SYSTEM	1999	15,373						26
27	DOORS	1999	2,750						27
28	DOOR	1999	200						28
29	EXTERIOR DOORS	1999	10,170						29
30	RETAINAGE - FIRE ALARM SYSTEM	1999	2,146						30
31	AUDIT ADJ 7/1/03 (#14) - PG12D, LINE 30	1999	(2,146)						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,124,941	$ 132,994		$ 132,994	$	$ 3,082,091	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Heartland of Macomb # 0049585 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,124,941	$ 132,994		$ 132,994	$	$ 3,082,091	1
2	DOOR ALARM	1999	1,475						2
3	SIDEWALKS	1999	9,020						3
4	SMOKING SHELTER	1999	4,950						4
5	PAVING	1999	4,950						5
6	WALLCOVERING	2000	61						6
7	UPGRADE FIRE ALARM SYST	2000	1,121						7
8	CABINETS FOR BUSINESS OFFICE	2000	2,821						8
9	ELECTRICAL FOR BUS OFFICE	2000	375						9
10	ALARM SYSTEM REPAIRS	2000	808						10
11	CONSTRUCTION & DESIGN OVERHEAD & INTEREST	2000	10,258						11
12	AUDIT ADJ 7/1/03 (#15) - PG12E, LINE 11	2000	(10,258)						12
13	HVAC	2000	18,151						13
14	HVAC CONSULTANT	2000	1,080						14
15	CARPET	2000	820						15
16	ADDL'T COST COUNTER TOPS	2000	313						16
17	CABINETS	2000	2,391						17
18	CARPET	2000	1,931						18
19	THERMO STAT	2000	1,594						19
20	FRT ON CARPET	2000	72						20
21	SOIL UTILITY RENOVATION	2000	3,240						21
22	SOIL UTILITY RENOVATION	2000	360						22
23	CABINETS/COUNTERTOPS	2000	266						23
24	KITCHEN HVAC	2000	2,017						24
25	SOIL UTILITY RENOVATION	2000	2,640						25
26	DUMPSTER ENCLOSURE	2001	2,457						26
27	WALLCOVERINGS	2001	121						27
28	ADDITONAL COST PAINTING & VWC	2001	1,238						28
29	PAINTING & VWC	2001	138						29
30	CUSTOM CABINETS	2001	5,289						30
31	INSTALL CARPET	2001	641						31
32	(42) WINDOWS & INSTALLATION	2001	22,328						32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,217,609	$ 132,994		$ 132,994	$	$ 3,082,091	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Heartland of Macomb # 0049585 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 3,217,609	$ 132,994		$ 132,994	$	$ 3,082,091	1
2	ADDITIONAL COST - (42) WINDOWS & INST	2001	2,481						2
3	PAINTING	2001	2,880						3
4	PAINTING	2001	320						4
5	General Constr. - Plumbing	2002	1,236						5
6	Interior Renov. - Wallcoverings	2002	822						6
7	AUDIT ADJ 7/1/03 (#16) - PG12F, LINE 6	2002	(822)						7
8	Interior Renov. - Wallcoverings	2002	44,760						8
9	Interior Renov. - Plumbing	2002	1,394						9
10	Building Addition - Wallcovering	2002	4,077						10
11	Border	2002	154						11
12	Additional Cost - Wallcovering	2002	196						12
13	Additional Cost - Wallcovering	2002	481						13
14	HVAC Electrical & Plumbing	2002	33,930						14
15	HVAC Electrical & Plumbing	2002	3,770						15
16	VWC	2002	496						16
17	Building Addition - Landscaping	2002	1,190						17
18	Building Addition - Landscaping	2002	6,442						18
19	Flooring and VWC	2002	4,823						19
20	Carpeting, Painting and Wallcovering	2003	12,897						20
21	7/1/06 Capital Rate Adj #1	2003	(12,897)						21
22	Developers Costs - Overhead	2003	211,116						22
23	7/1/06 Capital Rate Adj #2	2003	(211,116)						23
24	Architect & Engineering Fees	2003	91,070						24
25	Reproduc, Permit & Plan Fees	2003	15,980						25
26	7/1/06 Capital Rate Adj #3	2003	(5,165)						26
27	7/1/06 Capital Rate Adj #4	2003	(10,815)						27
28	Developers Costs - Interest	2003	16,397						28
29	7/1/06 Capital Rate Adj #5	2003	(16,397)						29
30	Millwork & Electric Service	2003	17,781						30
31	7/1/06 Capital Rate Adj #6	2003	(4,641)						31
32	7/1/06 Capital Rate Adj #7	2003	(13,140)						32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,417,309	$ 132,994		$ 132,994	$	$ 3,082,091	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Heartland of Macomb # 0049585 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 3,417,309	$ 132,994		$ 132,994	$	$ 3,082,091	1
2	Developers Costs - Overhead	2003	3,196						2
3	7/1/06 Capital Rate Adj #8	2003	(3,196)						3
4	Developers Costs - Interest	2003	276						4
5	7/1/06 Capital Rate Adj #9	2003	(276)						5
6	Carpeting, Painting and Wallcovering	2003	47,947						6
7	Soil & Concrete Testing	2003	3,480						7
8	Water & Sewer Fees	2003	120						8
9	7/1/06 Capital Rate Adj #10	2003	(120)						9
10	Site Work General Contractor	2003	32,561						10
11	7/1/06 Capital Rate Adj #11	2003	(32,561)						11
12	Retro Cost Adjustment	2003	45,504						12
13	7/1/06 Capital Rate Adj #12	2003	(45,504)						13
14	Window Treatments	2003	8,850						14
15	Soil and Concrete Testing (Addtl Costs)	2003	2,110						15
16	7/1/06 Capital Rate Adj #15	2003	(2,110)						16
17	Engineering Fees	2003	9,194						17
18	7/1/06 Capital Rate Adj #16	2003	(9,194)						18
19	Double Egress Door	2004	5,905						19
20	Construction Drawings & Specs	2004	5,998						20
21	Carpetry, Case Work, Painting	2004	37,880						21
22	Retainage for Addition	2005	1,533						22
23	Flooring, Corner Guards	2005	14,903						23
24	7/1/06 Capital Rate Adj #13	2005	(1,455)						24
25	7/1/06 Capital Rate Adj #14	2005	(55)						25
26	Materials to Complete Addition Project	2005	24,280						26
27	Physical Therapy Addn - LI - Soil Testing	2006	3,773						27
28	Physical Therapy Addn - LI - Landscaping	2006	24,893						28
29	Physical Therapy Addn - LI - Permit Fees	2006	5,423						29
30	Physical Therapy Addn - BI - Genl Contracting	2006	428,270						30
31	Physical Therapy Addn - BI - Carpeting	2006	6,948						31
32	Physical Therapy Addn - BI - Electrical	2006	288						32
33	Physical Therapy Addn - BI - Arch & Eng	2006	51,475						33
34	TOTAL (lines 1 thru 33)		$ 4,087,645	$ 132,994		$ 132,994	$	$ 3,082,091	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Heartland of Macomb # 0049585 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 4,087,645	$ 132,994		$ 132,994	$	$ 3,082,091	1
2	Physical Therapy Addn - BI - Genl A/H	2006	17,950						2
3	Corr & Main Dining Room - BI - Genl O/H	2006	7,409						3
4	Corr & Main Dining Room - BI - Carpentry	2006	26,688						4
5	Corr & Main Dining Room - BI - Wallcovering	2006	36,561						5
6	HR Office, BB Shop Renovation - BI - Carpet, Wallcovering	2007	6,145						6
7	Fire Safety Caulking	2007	24,060						7
8	Siding and Soffits on Gar	2007	5,100						8
9	Fire Walls and Caulking	2007	24,060						9
10	Cabinets in Beauty Shop	2007	2,982						10
11	FIRE WALLS AND CHALKING	2007	(24,060)						11
12	RENOVATE BREAKROOM - PLUMBING	2008	1,174						12
13	RENOVATE BREAKROOM - CABINETRY	2008	2,321						13
14	RENOVATE BREAKROOM - CEILING	2008	853						14
15	RENOVATE BREAKROOM - PAINTING	2008	704						15
16	RENOVATE BREAKROOM - VINYL TILE FLOORING (VCT)	2008	1,323						16
17	PAINTING CLOSETS	2008	9,850						17
18	ADJ PAINTING CLOSETS	2008	4,174						18
19	Water Heater	2009	16,031						19
20	Water Heater	2009	1,781						20
21	BI 010345 plumbing for asset 10342-dishwasher	2010	19,574						21
22									22
23	10354 Water Lines	2010	8,600						23
24	10355 roof duct	2011	14,367						24
25	10356 Add'l cost roof duct	2011	8,499						25
26	10371 HEAT EXCHANGER	2011	3,835						26
27	10372 Add'l cost roof duct	2011	2,520						27
28	10374 VWC, BASE, & CHAIR RAILS	2011	5,550						28
29	10375 VWC & ORDER, PAINT	2011	5,277						29
30	10397 STORAGE SHED	2012	4,500						30
31									31
32	10403 ICE MACH IN MAIN DINING ROOM	2013	8,600						32
33	10404 REP WALK/EMER EGRESS @ SIDE OF BLDG	2013	1,975						33
34	TOTAL (lines 1 thru 33)		$ 4,336,048	$ 132,994		$ 132,994	$	$ 3,082,091	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Heartland of Macomb # 0049585 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 4,336,048	$ 132,994		$ 132,994	$	$ 3,082,091	1
2	10405 REPLACE SMOKE DOORS BY ACTIVITIES	2013	5,250						2
3	10409 SEWER LINE REPLACEMENT	2013	123,120						3
4	10412 0513 Roof Replacement-Main Bldg	2013	195,307						4
5	10414 REPLACE SMOKE DOORS BY ACTIVITIES	2013	5,250						5
6	10415 REP WALK/EMER EGRESS @ SIDE OF BLDG	2013	1,975						6
7									7
8	10421 80 GAL HOT WATER HEATER replaced	2014	16,110						8
9	10429 PAVING-asphalt patching	2014	12,004						9
10									10
11	10430 Boiler Heat Exchanger & Burner replaced	2015	20,205						11
12	10435 Breaker Panel, 100 amp, in boiler room	2015	8,550						12
13	10439 Parking Lot Striping & Sealing	2015	10,790						13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,734,609	$ 132,994		$ 132,994	$	$ 3,082,091	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Heartland of Macomb # 0049585 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,467,720	$ 42,697	$ 42,697	$		$ 1,337,763	71
72	Current Year Purchases	14,135						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			6,370	6,370			74
75	TOTALS	$ 1,481,855	$ 42,697	$ 49,067	$ 6,370		$ 1,337,763	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	1986 Van retired in 2015			$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,322,709	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 175,691	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 182,061	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 6,370	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,419,854	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Heartland of Macomb # 0049585 Report Period Beginning: 01/01/15 Ending: 12/31/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2016	$
13.	/2017	$
14.	/2018	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 48,580 Description: O2 Concentrators, Wheelchairs, Geri Chairs, Elec. Beds, etc.
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Patient Transportation	2008 Ford X E-350 Cutaw	$ 55.00	$ 6,204	17
18					18
19				above figure includes	19
20				gas & maintenance	20
21	TOTAL		$ 55.00	$ 6,204	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Heartland of Macomb # 0049585 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Heartland of Macomb # 0049585 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	1198 hrs	$ 53,068	619	$ 43,791	$ 500	1,817	$ 97,359	1
2	Licensed Speech and Language Development Therapist	10a	1779 hrs	78,801	15	1,081	2,749	1,794	82,631	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	3393 hrs	150,276	9	665	7,454	3,402	158,395	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 2	# of prescrpts				156,485		156,485	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): IV Therapy	43, 2					1,284		1,284	12
13	Other (specify): EKG, X-ray & Lab	43, 3				64,074			64,074	13
14	TOTAL			$ 282,145	643	$ 109,611	$ 168,472	7,013	$ 560,228	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Heartland of Macomb # 0049585 Report Period Beginning: 01/01/15 Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/15 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 3,439	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 241,265)	578,381		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 581,820	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	106,245		13
14	Buildings, at Historical Cost	4,734,608		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,481,855		16
17	Accumulated Depreciation (book methods)	(4,419,854)		17
18	Deferred Charges	2,513,300		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe OMIT			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,416,154	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,997,974	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 60,826	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	213,402		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	60,203		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	88,377		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 422,808	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	555,518		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 555,518	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 978,326	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,019,648	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,997,974	$	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,287,151	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,287,151	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(325,251)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (325,251)	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	57,748	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 57,748	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,019,648	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,742,198	1
2	Discounts and Allowances for all Levels	(2,131,091)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,611,107	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,773,676	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,773,676	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	604	12
13	Barber and Beauty Care	9,042	13
14	Non-Patient Meals	18,016	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	308,195	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	48,571	19
20	Radiology and X-Ray	23,079	20
21	Other Medical Services	30,217	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 437,724	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income & Purchase Discount		28
28a	Purchase Discounts	436	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 436	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,822,943	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	840,865	31
32	Health Care	2,368,753	32
33	General Administration	1,626,391	33
	B. Capital Expense		
34	Ownership	900,308	34
	C. Ancillary Expense		
35	Special Cost Centers	251,429	35
36	Provider Participation Fee	160,448	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,148,194	40
41	**Income before Income Taxes (line 30 minus line 40)****	(325,251)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (325,251)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,576,199	44
45	Private Pay - Net Inpatient Revenue	1,017,865	45
46	Medicare - Net Inpatient Revenue	657,994	46
47	Other-(specify) Hospice	204,672	47
48	Other-(specify) Insurance	154,377	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,611,107	49

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,974	2,141	$ 73,018	$ 34.10	1
2	Assistant Director of Nursing	3,721	4,035	109,353	27.10	2
3	Registered Nurses	14,330	15,540	347,355	22.35	3
4	Licensed Practical Nurses	12,369	13,413	252,238	18.81	4
5	CNAs & Orderlies	50,681	55,172	588,849	10.67	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	8,677	9,408	416,697	44.29	7
8	Rehab/Therapy Aides	5,753	6,238	182,607	29.27	8
9	Activity Director	3,679	3,998	54,095	13.53	9
10	Activity Assistants					10
11	Social Service Workers	3,374	3,666	81,390	22.20	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,072	18,553	224,045	12.08	15
16	Dishwashers					16
17	Maintenance Workers	2,075	2,254	42,039	18.65	17
18	Housekeepers	9,240	10,040	114,589	11.41	18
19	Laundry	1,704	1,850	17,582	9.50	19
20	Administrator	2,080	2,080	103,794	49.90	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,970	10,988	200,235	18.22	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,055	2,230	36,814	16.51	31
32	Other Health Care(specify)					32
33	Other(specify)	1,989	2,161	22,294	10.32	33
34	TOTAL (lines 1 - 33)	150,743	163,767	$ 2,866,994 *	$ 17.51	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	3,318	9, 3	36
37	Medical Records Consultant	Monthly	2,050	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 5,368		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10, 3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Christie Butler (Jan-Aug)	Administrator	0	$ 54,265
Athena Brooks (Sept-Dec)	Administrator	0	49,529
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 103,794

B. Administrative - Other

Description	Amount
Various Home Office Services - See page 8 for breakdown	$ 253,109
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 253,109

C. Professional Services

Vendor/Payee	Type	Amount
Anspach Meeks Ellenberger LLP	Legal Fees	$ 69
Elvidge Kelley Attorney At Law	Legal Fees	2,325
Polsinelli Shughart PC	Legal Fees	104
SNF Global	Legal Fees	20,655
(Legal Fees were adjusted off via Page 5, Line 22; therefore no invoices are attached)		
Transworld Systems Inc	Collection Services	1,276
(Collection Costs were adjusted off via Page 5a, Line 4)		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 24,429

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 29,829
Unemployment Compensation Insurance	44,148
FICA Taxes	201,634
Employee Health Insurance	199,535
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Appreciation	
401K	3,048
Oth Empl Benefits & Marketing Adjustment	4,480
Tuition Reimbursement	
SMSP Match	8
Employee Uniforms	4,672
Home Office Allocation	18,711
TOTAL (agree to Schedule V, line 22, col.8)	$ 506,065

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	13,537
Health Care Worker Background Check (Indicate # of checks performed 138)	4,269
Patient Background Checks 300	3,000
Dues & Subscriptions	2,821
Association Dues	5,060
Advertising	59,966
Other Licenses & Permits	319
Less: Non-allowable Assn. Dues	(2,007)
Less: Public Relations Expense	( )
Non-allowable advertising	(59,966)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,999

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	13,822
Includes travel expense to the Home Office in Toledo, OH for regional meetings.	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,822

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ICHA $1876 & AHCA $1177**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **5-10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **33,518** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **YES**
If YES, give effective date of lease. **04/07/11**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **160,448**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **18,016**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name:

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **NO**
Attach invoices and a summary of services for all architect and appraisal fees.